



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

HOUSTON TX 77030

Requestor Name and Address

FONDREN ORTHOPEDIC GROUP
7401 S. MAIN

Respondent Name

SEABRIGHT INSURANCE CO

Carrier's Austin Representative Box

Number 19

MFDR Tracking Number

M4-12-3309-01

MFDR Date Received

July 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Reconsideration letter dated April 12, 2012: "...CPT Code Q4038 is UNDERPAID. We expect payment per the DWC fee schedule which follows Medicare policy. The Medicare allowable is \$37.55 and as this is a DME/CASTING charge it is payable at 125% of the Medicare allowable..."

Amount in Dispute: \$7.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A response was not received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2011	Q4038 casting supplies	\$7.45	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 Texas Register 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets forth the guidelines for professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1 amended to be effective March 1, 2008, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.

4. The services in dispute were reduced by the respondent with the following reason codes:

Explanations of benefits

- 850-003 – reimbursement has been calculated according to the state fee schedule guidelines
- ST-P – state/province pricing
- 850-001 – for further consideration of reimbursement, please submit the manufacture invoice for our review

Issues

1. Does HCPCS code Q4038 have a fee listed in DMEPOS or Medicaid?
2. Is the requestor entitled to additional reimbursement?

Findings

1. According to 28 Texas Administrative Code §134.203(a)(5), "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

28 Texas Administrative Code §134.203(b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 Texas Administrative Code §134.203 (d) states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

The Division finds that HCPCS code Q4038 does not have a fee listed in DMEPOS fee schedule nor a Medicaid rate.

28 Texas Administrative Code §134.203 (f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1(f) requires in pertinent part, that reimbursement shall: "(1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307 effective May 31, 2012, paragraph (c)(2)(O) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:

- The requestor did not submit documentation to support how additional payment of \$7.45 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor did not submit nationally recognized published studies, published division medical dispute decisions, or documentation of values assigned for services involving similar work.

- The requestor did not discuss or support that similar procedures provided in similar circumstances received similar reimbursement.
 - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code 413.011(d).
2. The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services involved in this dispute.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	Date

March , 2013

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.